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Abstract

The purpose of this study was to examine the progress of individuals enrolled in the Washington County Mental Health Court (MHC) and factors that may be related to their progress. Participants in the MHC were interviewed and information was obtained about factors that may be related to progress. To determine progress of the participants, a newly implemented tool called the Results Assessment and Monitoring Progress (RAMP) was utilized. Initial scores were determined at the time that the participant entered the MHC and a current score was determined at the time of the interview.

A significant positive correlation was found that indicated that participants who were involved in the MHC for a greater number of days had a greater improvement on the RAMP. Also, positive correlations were found among measures of perceived procedural justice, impact of court, and average ratings of MHC staff.

Participant variables were examined to determine whether they appeared to be related to an improvement in RAMP scores. No significant results were found, but noticeably large differences indicated that individuals who were employed, those with an education level of 12th grade or less, those who had been set back to Phase I, those with an adequate support system, and those who lived in a group home or treatment facility appeared to have a larger RAMP difference score than other groups for these variables.

Finally, observations were made to examine trends for several categories of participants: participants in Phase III, those set back to Phase I, participants with a large RAMP difference score, those with a small RAMP difference score, individuals who were not satisfied with the MHC, individuals who had been enrolled for more than 800 days, and those who had been enrolled for less than 200 days.

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PROGRESS IN A MENTAL HEALTH COURT

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

BY

LACEY OLDEMEYER

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OF

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Table of Contents

Abstract	ii
Acknowledgements	iv
List of Tables	vii
Introduction	1
Review of the Literature	3
Criminalization of Individuals with Mental Illness.....	3
Therapeutic Jurisprudence.....	7
Problem-Solving Courts.....	8
Characteristics of Mental Health Courts.....	10
Operations of Mental Health Court.....	11
Second-Generation Mental Health Courts.....	17
Coercion and Voluntariness.....	19
Effectiveness of Mental Health Courts.....	21
Purpose of the Current Study.....	31
Method	32
Mental Health Court.....	32
Participants.....	33
Assessment Measures.....	35
Procedures.....	37
Results	39

Descriptive Statistics.....	39
Correlational Analysis.....	39
Non-parametric Tests.....	41
Non-statistical Observations and Trends.....	43
Discussion.....	46
Summary of Results.....	46
Strengths and Limitations of Current Research.....	54
Implications of the Current Study.....	55
Directions for Future Research.....	57
Conclusions.....	58
References.....	58
Appendix A.....	62
Appendix B.....	68
Appendix C.....	69
Appendix D.....	70

List of Tables and Figures

	Page
Table 1: Demographics of Participants.....	33
Table 2: Descriptive Statistics for Numerical Variables.....	39
Table 3: Results for Pearson Product-Moment Correlations.....	41
Table 4: Median Scores on the RAMP.....	42
Table 5: Median scores on Perception Measures Before and After Change in Judge.....	43
Figure 1: Scatter Plot of days involved in Mental Health Court and RAMP Difference Scores.....	40

Introduction

It is unfortunately all too common for individuals diagnosed with mental illness to have contact with the criminal justice system (Crilly, Caine, Lamberti, Brown, & Friedman, 2009; Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Ditton, 1999; Steadman, Osher, Robbins, Case, & Samuels, 2009; Torrey & Mays, 1995). These individuals have been known to get caught in a revolving door cycle in which they are incarcerated often for minor crimes and then are released back to the community, without services or resources, where they commit another offense and are rearrested. This vicious cycle has led to the criminalization of individuals with mental illness and it represents a major concern for mental health and criminal justice professionals.

In the effort to reverse, or at least slow, criminalization of this population, mental health courts (MHCs) have recently been developed (Lurigio & Snowden, 2009). MHCs were put into place to divert individuals with mental illness from the legal system to a system in which they can receive treatment and services to prevent them from engaging in the revolving door cycle. Research conducted to determine the effectiveness of MHCs have shown promising findings; however, there has not been any research to date to determine what factors may contribute to MHC participants' progress or lack of progress. In this study, I examined the outcome of participants in an MHC based on a tool utilized by the Washington County MHC and attempted to identify contributing factors that may have a role in whether the participants progress or do not progress. In the following review of the literature, I examine the prevalence of individuals in the criminal justice

system, the historical antecedents and components of MHCs and current research of the effectiveness of MHCs

Review of the Literature

Criminalization of Individuals with Mental Illness

The criminalization of individuals with mental illness has been an increasing concern in the criminal justice and mental health fields. For example, Deane et al. (1999) surveyed 174 police departments and found that 7% of police contacts, investigations, and complaints involved individuals who were believed to be mentally ill. James and Glaze (2006) used data from a nationwide survey and found that, in 2005, 56% of state inmates, 45% of federal inmates, and 64% of jail inmates had mental health problems. They identified an inmate as having mental health problems if he or she had been given a diagnosis of a mental disorder, had received treatment for a mental disorder, or had experienced symptoms based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR*; American Psychiatric Association, 2000) in the 12 months prior to the point at which the information was obtained from the inmate. It has been estimated that approximately 16% of state inmates, 7% of federal inmates, and 16% of jail inmates have reported being diagnosed with a mental disorder or having stayed overnight at a psychiatric hospital (Ditton, 1999).

More recently, Steadman et al. (2009) conducted a study of male and female inmates in five jails (two in Maryland and three in New York) to determine the prevalence of severe mental illness among jail inmates. They defined severe mental illness as a diagnosis of major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, or not otherwise specified; a schizophrenia spectrum

disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; or psychotic disorder not otherwise specified. They found that 14.5% of male inmates and 31.0% of female inmates had a severe mental illness. Looking at status after incarceration, Crilly et al. (2009) found mental illness to be relatively common among male and female individuals on probation. They found that 26.6% of individuals on probation had at least one symptom of mild severity that mildly impacted functioning. Ditton (1999) also found that mental disorders were common among probationers. They found that 16% of probationers reported symptoms of a mental disorder or an overnight stay at a psychiatric hospital.

Another common issue for offenders with mental illness is that they are less likely to be released on bail and more likely to spend more pre-trial days in jail than are those without mental illness. Torrey and Mays (1995) found in King County Jail (in Seattle, Washington) that individuals with mental illness spent an average of 34 days in jail before their trial. This was approximately 3 times as long as the time in jail prior to trial for individuals without a mental illness. Similarly, in Fairfax County Jail in Virginia, inmates who experienced psychosis spent approximately 27 days incarcerated before their trial, whereas those who were not mentally ill spent approximately four days incarcerated.

Ditton (1999) found that offenders diagnosed with mental illness were more likely to be convicted of less serious offenses (such as property theft, disorderly conduct, or trespassing) than were offenders who were not mentally ill. According to Ditton, approximately half of offenders with a mental illness convicted and sentenced to prison had committed nonviolent offenses, although they tended to receive longer

sentences than did offenders who did not have a mental illness and to serve the maximum length of time. Ditton reported that although inmates diagnosed with a mental illness in jail typically served about 9 months (which was 2 months less than inmates who were not mentally ill), offenders diagnosed with mental illness sentenced to state prisons served approximately 103 months in prison, which was about 15 months longer than other inmates.

These studies reflect how individuals with mental illness are involved at disproportionate rates and may receive harsher punishment in the criminal justice process as compared with individuals who are not mentally ill. The question arises as to what can be done to prevent so many individuals with mental illness from coming into contact with the criminal justice system or at least to reduce the frequency of this contact. To address this question, we first need to consider what may have contributed to the criminalization of individuals with mental illness.

Lamb, Weinberger, and Gross (2004) suggested several reasons for the criminalization of individuals with mental illness. The first theory, and a popular one, is the process of deinstitutionalization. In 1955 there were an estimated 559,000 patients in state hospitals (339 beds per 100,000 people) in the United States. In the 1950s, funding for state hospitals was reduced dramatically with the goal of moving toward more community-based treatment for these individuals; however, the community-based treatment programs did not develop at a rate necessary to meet the needs of those released from state hospitals. At the end of 2000, there were about 55,000 available beds in state hospitals (20 beds per 100,000 people), which represented about a 90% decrease since 1955. Lamb et al. theorized that the result of

this drastic decrease in the number of state hospital beds has been an increase in arrest and incarceration of individuals with mental illness.

Lamb et al. (2004) identified increasingly stringent civil commitment policies and laws as another factor contributing to the criminalization of the mentally ill. Beginning in 1969, new civil commitment laws were developing across the nation. This change included moving away from criteria that utilized general concepts of mental illness and a need for treatment to criteria that required an assessment of risk of dangerousness or incapacity to care for oneself as a result of mental illness. It also included a shift from indeterminate and long-term commitments to determinate short-term commitments. The new laws provided and required more access to courts, attorneys, and jury trials to ensure due process to civilly committed individuals. It has been argued that now only the most dangerous and impaired individuals are civilly committed, whereas individuals who may actually be in need of hospitalization may not receive it, leaving them in the community without help to care for themselves or monitor their behavior (Lamb et al., 2004).

A third factor that may contribute to the criminalization of the mentally ill is the lack of adequate community support systems. Lamb et al. (2004) argued that an important part of providing community support to individuals with mental illness is the availability of community treatment resources; however, current resources are not sufficient for the number of individuals with mental illness who reside in the community. The authors also argued that the services and resources available also might not be suitable for the population in need of them. Slate (2003) suggested that part of the problem related to available community support and treatment could be

explained by the fact that private psychiatric hospital staff and care providers are selective when deciding whom they will treat, which can result in turning away indigent individuals with mental illness.

Goldkamp and Irons-Guynn (2000) suggested that an interaction among multiple factors has resulted in the criminalization of the mentally ill. The authors argued that the increase in homeless individuals with mental illness and substance use, engagement in quality-of-life violations and ordinance infractions, in addition to the War on Drugs and a get-tough-on-crime attitude, have led to the involvement of more individuals with mental illness in the criminal justice system. Unfortunately, this involvement may actually be the only opportunity for them to receive any kind of treatment.

Therapeutic Jurisprudence

The studies just discussed show that individuals with mental illness are often criminalized; that is, they become involved in the criminal justice system at a relatively high rate. In recognition of this trend, and with an understanding that the legal process can be an anti-therapeutic and possibly detrimental experience for individuals with mental illness, the concept of *therapeutic jurisprudence* has become more prevalent in the implementation of laws that involve individuals with mental illness (Wexler, 1999). Wexler first introduced the concept of therapeutic jurisprudence in 1987, and he defined it as “the study of the law as a therapeutic agent” (Wexler, 1999, p. 1). Later, Slobogin (1995) proposed a new definition of therapeutic jurisprudence, as follows: “...the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects” (p. 196).

A number of other definitions of therapeutic jurisprudence have been proposed; however, a common theme is that the law serves as a social force and therapeutic agent to promote psychological health and social interests in addition to ensuring due process in every case (Wexler & Winick, 1996). Wexler (1999) identified three categories into which the law can be divided: legal rules, legal procedures, and the roles and behaviors of the legal actors. Therapeutic jurisprudence can be considered in each of these categories. Wexler claimed that therapeutic jurisprudence allows for reasoning and rehabilitation to be used in each of these categories.

When working from a therapeutic jurisprudence framework, decisions are made while considering the impact the decisions may have on individuals, their relationships, and society even after contact with the criminal justice system has ended. With recognition of the potential effects the criminal justice system may have on individuals, especially those diagnosed with mental illness, and the development of the concept of therapeutic jurisprudence, problem-solving alternatives have been developed to promote positive mental health for those in need of treatment (Lurigio & Snowden, 2009). Some of these alternatives will be discussed in the next section.

Problem-Solving Courts

Gurrera (2005) described a problem-solving court as a specialty court that is based on the concept of therapeutic jurisprudence and that provides a more meaningful approach to justice for individuals who have mental health or substance use problems. The first problem-solving court was developed in Florida's Dade County in response to the large number of drug offenders who had been cycling in and out of the criminal justice system; this was the first drug court in the country (Lurigio & Snowden, 2009).

County officials recognized addiction as a mental health issue that promoted criminal behavior and that was therefore treatable. Drug courts gave drug offenders a choice to either plead guilty and participate in mandatory treatment or go to trial and possibly be convicted and receive jail or prison time. Offenders who chose to go to drug court were involved in nonadversarial court proceedings where they were informed of the conditions of the program (Lurigio & Snowden, 2009). They would receive regular contact with the judge and have intensive supervision and random drug tests, and there would be rewards and punishments to encourage compliance. This court represented the beginning of a new philosophy; that is, courts could make decisions to intervene and treat offenders rather than simply lock them up. Along these lines, another new procedure that drug courts introduced was the development of cooperative relationships among legal and mental health professionals (Goldkamp & Irons-Guynn, 2000).

Many other jurisdictions developed their own drug court programs as a more effective and efficient way to deal with drug offenders (Lurigio & Snowden, 2009). Along with this innovative system came the ability to identify special problems, which led to the recognition of a high prevalence of mental illness in individuals being admitted into the drug court program. This recognition paved the way for the development of mental health courts (MHCs; Lurigio & Snowden, 2009).

Based on the same philosophy as drug courts, the first MHC was developed to operate from a therapeutic jurisprudence framework in Broward County, Florida, in 1997 (Goldkamp & Irons-Guynn, 2000). The purpose of MHCs was to reduce the criminalization of individuals with mental illness and provide treatment for them rather than incarcerate them repeatedly for minor offenses. The new system became known in

other jurisdictions, and other MHCs were eventually implemented in other states and counties (Lurigio & Snowden, 2009). In 2000 the resources available to expand the implementation of MHCs were increased when the America's Law Enforcement and Mental Health Act was passed and \$4 million dollars was dispensed to support the development of MHCs across the nation (Lurigio & Snowden, 2009). The number of MHCs in the country exploded from one court in 1997 to 180 courts in 2008 (Council of State and Local Governments, 2008).

Characteristics of Mental Health Courts

Redlich, Steadman, Monahan, Robbins, and Petrila (2006) identified six characteristics of MHCs. The first is that MHCs have separate dockets for criminal court cases for offenders with mental illness. The criteria to be included on the MHC docket may vary in each county, but the court is separate from the other traditional court dockets and is only open to those diagnosed with mental illness.

The second characteristic of MHCs identified by Redlich et al. (2006) is that the purpose of an MHC is to reduce the incarceration cycle in which individuals with mental illness are often involved. The goal of MHCs is to increase treatment in the community in addition to reducing both recidivism and the number of individuals with mental illness in jails and prisons. The third characteristic of the MHC is that it imposes conditions relevant to the individual's mental illness, which may include mandatory individual or group therapy and medication compliance. There may also be the incentive of having charges dropped if the participant is successful in treatment.

The fourth characteristic that Redlich et al. (2006) identified is that the participants are monitored via judicial status review hearings. In the judicial status

review hearing, the participants report their progress and compliance and can receive praise or sanctions for their actions. Fifth, MHCs work from the concept of therapeutic jurisprudence, using praise to encourage and reinforce even the smallest of successes. There may also be sanctions for noncompliance, but MHCs are typically more flexible than traditional courts in regard to conditions if modifications need to be implemented to increase the manageability for the individual. The final characteristic identified by Redlich et al. is that participation in MHC is voluntary. Participants must be given the choice of participating in MHC or continuing through the traditional court system.

Operations of Mental Health Courts

Operations of MHCs vary from county to county; however, like the characteristics identified above, there are some general aspects of MHC operations that tend to be similar across jurisdictions. For example, it is common for individuals who are identified as potential MHC participants to receive a referral within 24 or 48 hr from the time they are arrested (Goldkamp & Irons-Guynn, 2000). This referral often occurs while they are incarcerated in jail or at their arraignment, depending on the protocol for the court. In addition, in order for the offenders to be eligible to participate in MHC, in most jurisdictions the participant must have an Axis I diagnosis; however, some MHCs allow individuals with developmental disabilities, and very few allow individuals who have only an Axis II diagnosis (Goldkamp & Irons-Guynn, 2000). There are usually more specific criteria about eligible diagnoses in individual courts; for example, the disorder may need to be severe and persistent or in a specific category of diagnosis (such as schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder; Goldkamp & Irons-Guynn, 2000). Treatability and medication

compliance of individuals may also be considered in the eligibility criteria. Exclusion criteria may be considered as well; for example, an offender may not be accepted if he or she is charged with child abuse, sex offenses, or domestic violence charges, or if he or she is a first-time or chronic offender. The offenders must also be found to be competent to stand trial before they participate in MHC (Lurigio & Snowden, 2009).

Once an eligible individual voluntarily chooses to participate in MHC, the criminal charges may be handled differently in each court. Griffin, Steadman, and Petrila (2002) outlined three models of how courts handle participants' criminal charges. The first is the preadjudication model, in which participants do not undergo adjudication and charges are often held in abeyance until the participant completes the requirements of the MHC. The second is the postplea-based model in which adjudication occurs but the disposition or sentence is deferred. The third is the probation-based model in which participants must plead guilty and are convicted of an offense, and treatment is a term of probation.

To determine common operational procedures of MHCs, Redlich et al. (2006) surveyed 90 MHCs in 34 states about their court operations. The authors found a large range of active clients in the MHCs from three to 852. The median number of active clients was 36, and the mode was 30. The reported maximum number of clients who could be served ranged from 10 to 250, and half of the MHCs were serving the maximum number of clients they could serve. Redlich et al. found that about 50% of the courts permitted individuals with either misdemeanor or felony charges to participate in the MHC, 40% accepted only misdemeanor charges, and 10% accepted only felony charges. The authors also examined how MHCs monitored and supervised

the participants. Most MHCs did not rely on only one method of supervision: 70% of the MHCs reported that they used more than one method. The most prevalent method of supervision was monitoring by mental health professionals (79%), followed by supervision by probation officers (70%).

Steadman, Redlich, Griffin, Patrla, and Monahan (2005) examined the process of referral and dispositions in seven MHCs. The authors found 20% to 100% of referrals were accepted by the MHCs, and 100% of those accepted in five of the seven courts enrolled in the MHC. For individuals who were not accepted into the MHC the authors reported that the primary reason, accounting for 30% of the rejections, was that the individuals did not have a mental disorder that qualified for the MHC. The second most common reason, accounting for about 18% of rejections, was issues related to the individual's crime or criminal history. In addition, the authors examined the time that lapsed between referral and disposition and found that it ranged from an average of one day to more than 45 days.

Steadman et al. (2005) also explored characteristics of individuals referred to the MHCs and those accepted into the MHCs. The mean age was approximately 35.8 years for the MHCs. Overall, 60% of the individuals referred to the MHCs were male (with a range from 45% to 72%). When these numbers were compared to the number of males who make up the population of prisons, the authors suggested that females were more likely to be referred to MHCs than males. With regard to ethnicity, there was a large range of White individuals in MHCs: 8% to 93% were White. However, when compared to the large disproportion of minorities incarcerated the authors suggested that Whites are overrepresented in MHCs. Finally, the most common diagnoses for

individuals referred to MHC were schizophrenia spectrum disorders, bipolar disorder, and depressive/mood disorders (28.8%, 18.9%, and 22.5%, respectively).

Approximately, 15% of individuals referred did not have a mental health diagnosis.

In regard to those accepted into the MHCs, Steadman et al. (2005) found that of those referred to a MHC with a serious mental illness 76% were accepted; the most common diagnoses were schizophrenia, schizoaffective, and bipolar disorder. Referrals of individuals with other diagnoses were approximately equally likely to be accepted or rejected (44% were accepted). Additionally, the severity of mental illness and not gender or ethnicity positively predicted acceptance into the MHCs. However, there appeared to be a large variance in gender in individual courts; for example, one MHC accepted 69% of women referred and 38% of men, whereas another accepted 70% of women referred and 74% of men.

Relich et al. (2006) also explored the frequency of judicial status hearings. A majority of the MHCs modified the frequency of hearings based on progress made by the participant; less frequent hearings occurred when participants were compliant with court conditions and more frequent hearings occurred when participants were not compliant. The most common frequency of judicial status hearing when participants were initially enrolled in MHC was once per week (41%), followed by once per month (35%). Finally, Redlich et al. found that most of the MHCs (72%) used jail time as a sanction in only 20% or fewer of cases.

Redlich et al. (2010) conducted a study to examine the number of court appearances (i.e., status review hearings) that MHCs required versus the number that were attended by participants, the number of bench warrants that were issued, and the

number of appearances that were made while the individuals were in custody or out of custody. The researchers gathered information from 447 MHC participants from four MHCs. The results indicated that completion status (i.e., whether the participants graduated from the program or were terminated) was related to compliance, in that graduates were found to be more compliant with the court and have a better attendance rate than those found to be noncompliant and to have a poor attendance rate. It was also found that those who did not graduate from the MHC court attended fewer hearings during their time in court and had more bench warrants issued or stayed than those who graduated.

Redlich et al. (2010) also examined judicial supervision, which they defined as the number of court hearings attended divided by the number of days in the court, to account for the time spent in the court. Values ranged from .002 to .17 (a higher number indicated more frequent supervision). The authors also reported that 52% of the participants had no bench warrants, 43% had between one and four bench warrants, and one participant had 23 bench warrants. In regard to hearings in or out of custody, 48% of the participants had all of their hearings out of custody and 52% of the participants had 5% to 100% of their hearings in custody. Overall, Redlich et al. concluded that compliance, attending required status hearings, and having less bench warrants were related to successful completion of the MHC program.

Bazon (2004) examined sanctions for noncompliance and found that 36% of courts increased mandated services for the participants and 27% increased the frequency of supervision. If participants failed, 64% of MHCs' policies allowed for the participants to be placed in jail, and 18% removed the participants from the program.

Bothroyd, Poythress, McGaha, and Petrila (2003) specifically explored the process at the Broward Mental Health Court in Florida. The authors examined transcripts of 121 defendants in the MHC to determine who engaged in talking and in topics discussed during court. With respect to who spoke in court, they found that the judge accounted for 47% of utterances, the defendant for 33%, the attorneys for 12%, and mental health staff for 7% of the utterances.

With regard to topics that were discussed in the court, Bothroyd et al. (2003) found that topics were typically related to mental health and legal issues. They found that the purpose and focus of the mental health court was mentioned in 28.4% of cases and voluntary participation was discussed in 15.7% of cases. Competency to proceed was discussed in 29.4% of cases, and the defendant was found competent in 73.3% of these cases. Mental health issues were discussed in most cases and tended to be more extensive than the discussion about legal issues. Diagnoses and symptoms were mentioned in 42.2% of cases, psychotropic medications in 24.5% of cases, and treatment and placement issues in 83.6% of cases. Housing and employment was also discussed frequently (34% and 10.2%, respectively).

Boothroyd et al. (2003) also looked at linkage to treatment. For 35.3% of defendants a referral was made to an agency or where the defendant had previously or recently developed a treatment plan. Another 35.3% of defendants were referred to an agency that was determined to be appropriate for the defendant, and 11.1% of defendants were encouraged to initiate treatment on their own. Linkage information was not available for the remaining 18%. In addition, the authors explored how the MHC affected the defendants' treatment. They found that there was a significant

increase (from 36% to 53%) in the use of behavioral health services by the defendants in MHC eight months after enrollment in the MHC.

Second-Generation Mental Health Courts

Redlich, Steadman, Monahan, Petrila, and Griffin (2005) argued that a new generation of MHCs differed on four dimensions from the first generation of MHCs. The authors compared characteristics and operations of eight MHCs that had been examined previously by Griffin et al. (2002) to seven more recently established MHCs that had not been included in any prior studies. The first dimension examined was the type of charges accepted in the MHC. It was found that only one of the eight first-generation MHCs accepted felony charges, whereas all seven of the second generation of MHCs accepted felony charges. Three of the second-generation courts were described as courts that focused on felony charges; only one was described as a court that focused on misdemeanor charges. The authors also found that second-generation MHCs were more likely than first-generation MHCs to accept offenders who had committed violent offenses; only two of the first-generation MHCs accepted domestic violence and battery charges. In addition, second-generation MHCs were more likely to consider the totality of the circumstances than were the first-generation MHCs.

The second dimension examined by Redlich et al. (2005) was the type of adjudication model employed. Four of the first-generation MHCs employed primarily preplea models; however, six of the MHCs had the option to use a postplea model. Six of the second-generation MHCs only used the postplea model. One of the second-generation MHCs used the preplea model primarily, but about a fourth of the cases in that court were postplea. The authors suggested that part of the reason for this

transition to more postplea models was that referrals to MHCs occurred later in the legal process. In first-generation MHCs, individuals were typically referred within 24 to 48 hr of arrest, whereas in second-generation MHCs it was found that the individuals were not receiving referrals until an average of 28 days after arrest, with a range of 0 to 129 days after arrest.

The third dimension considered by Redlich et al. (2005) was the type of sanction used. Jail incarceration was used more frequently as a sanction in second-generation courts than in first-generation courts. Six of the first-generation MHCs rarely used jail as a sanction, whereas respondents from five of the second-generation MHCs reported that they were comfortable using jail as a sanction. However, a jail sanction was often used after other less punitive sanctions had been tried, and it was used with discretion and with the awareness that for some participants jail could result in detrimental effects. The authors speculated that more of the second-generation MHCs used jail as a sanction because they accepted more individuals with felony charges than with misdemeanor charges when compared to first-generation MHCs.

The final dimension that Redlich et al. (2005) examined was the type of supervision used. In first-generation MHCs, four included supervision from a probation officer or mental health professional, two used a team of mental health and criminal justice professionals, and one used supervision from a mental health provider in the community who reported to the MHC. In second-generation MHCs, one used solely a mental health professional in the community and the others used court personnel and/or probation to supervise. The authors reported that their purpose in comparing the two generations of MHCs was not to suggest one was more effective

than or superior to the other but rather to acknowledge that the characteristics and operation of MHCs appeared to be shifting.

Coercion and Voluntariness

An issue that appears to be of concern in the process of MHCs is possible or perceived coercion as well as the inclusion of procedural justice in MHCs. Poythress, Petrila, McGaha, and Boothroyd (2002) examined perceived coercion and perceived procedural justice of individuals involved in the Broward County MHC. The authors defined perceived procedural justice as the defendant's experience of the case disposition process. They identified two factors that affect perceived procedural justice: (a) the defendant having the opportunity to present his or her view of the situation being disputed, and (b) the defendant feeling that he or she was treated with respect by the decision maker. The authors found a very low amount of perceived coercion measured by the MacArthur Perceived Coercion Scale (MPCS), which is a 5-item measure used to assess coercion on a scale of 0 (*low*) to 5 (*high*). They found that the mean score across items measuring coercion was 0.69, suggesting that there was a very low perception of coercion by individuals participating in the MHC.

To measure perceived procedural justice the authors used the Perceived Procedural Justice (PPJ) measure, which is also a 7-item scale for rating perceived procedural justice on a scale of 1 (*low*) to 7 (*high*). The mean ratings on each of the items ranged from 5.39 to 6.57, suggesting that there was strong perceived procedural justice by the individuals in the MHC. When compared to the perceived procedural justice as rated by individuals involved in a traditional court there was a significant difference: The mean of each item for the traditional court participants ranged from

1.80 to 3.78, indicating a a higher level of perceived procedural justice by the individuals involved in the MHC than those involved in the traditional court.

Poythress et al. (2002) also argued that the emotional impact of the court proceedings was related to individuals' perceived procedural justice; to assess this factor, they used the Impact of Hearing scale (IOH) to determine how participants were emotionally affected by the court hearing. The IOH is a 6-item scale on which the participant rates items from 1 (*negative feelings*) to 7 (*positive feelings*) after his or her hearing. Mean ratings on each of the items ranged from 5.54 to 6.07; this range was significantly higher than the mean ratings of individuals involved in a traditional court, which ranged from 3.36 to 3.98.

Another issue that arises related to coercion is the voluntariness of MHCs, which, as previously discussed, is a crucial characteristic of MHCs (Redlich et al., 2006). Redlich, Hoover, Summers, and Steadman (2008) conducted interviews with MHC participants to examined the voluntariness, knowingness, and adjudicative competence of MHC participants. They found that more than half of the participants (a) agreed that it was their decision to participate in the MHC, (b) understood that only certain individuals could participate in the MHC, (c) could identify advantages of the MHC, and (d) showed minimal to no impairment on a measure of adjudicative competence. However, more than half of the participants reported that they (a) had not been told that entrance into the MHC was voluntary before they agreed to enroll; (b) were not informed of the requirements of the MHC before they enrolled; (c) did not know that the final decision, after criteria for enrollment was met, was theirs to make; (d) did not know they could terminate their participation in the MHC if they chose; and

(e) could not identify any disadvantages of participating in the MHC. The authors concluded that it was questionable whether individuals were making their decisions voluntarily, knowingly, and competently, and they suggested that MHC staff should take careful precautions to ensure that individuals were provided information to make informed decisions about whether to participate in MHCs.

These studies appear to indicate that most individuals do not believe that they had been coerced into participating in the MHC and felt satisfied with their interactions in the court. It was also found that participants understood relevant information related to their involvement in the MHC, which suggested they were making a decision voluntarily, knowingly, and were competent to do so; however, some individuals also lacked knowledge of important information (e.g., that entrance into the MHC was voluntary and he or she could choose to terminate from the MHC at any time) when making a decision. These results indicate that MHC staff should be ensuring that potential participants receive all information necessary to permit a competent, voluntary, and knowing decision-making process.

Effectiveness of Mental Health Courts

Although the implementation of MHCs is relatively new, a number of researchers have attempted to examine their effectiveness. Herinckx, Swart, Ama, Dolezal, and King (2005) conducted a study to examine three factors: (a) whether the participants received more mental health services in the 12 months after they entered the MHC than they had received in the 12 months before they entered the MHC, (b) whether the participants' recidivism was reduced in the 12 months after they entered the MHC compared to the 12 months before they entered the MHC, and (c) whether

any factors were associated with recidivism. In regard to linkage to mental health services, the authors determined that individuals were linked to a mental health service within 3 to 10 days after they entered the MHC. They also found that the participants received more hours of case management and medication management as well as more days of outpatient services after they entered the program compared to what they had received before they entered the program. In addition, Herinckx et al. found that the participants received fewer hours of crisis intervention and inpatient treatment after they entered the program in comparison to the amount received prior to program entry.

With respect to the reduction of recidivism, Herinckx et al. (2005) found that the 368 offenders in the MHC had been arrested a total of 713 times in the 12 months before they entered the program. After entrance into the program, 199 of the participants were not arrested during the subsequent 12 months. The 169 participants who had been arrested had a total of 178 arrests in the 12 months after entering the MHC, which is significantly fewer than the total number of arrests before entering the MHC. Overall crime rate for the MHC participants decreased by 400% one year after they were enrolled in the MHC. There was a 62% decrease in rearrest for probation violations.

Herinckx et al. (2005) also examined factors that predicted rearrest and success. The results indicated that graduation from the program was the most predictive factor of success. More specifically, participants were 3.7 times more likely to reoffend if they had not graduated from the program than if they had graduated. Participants who were hospitalized for mental illness during the 12 months prior to entering the MHC were twice as likely to be rearrested within 12 months of entering. In addition, those

who had been arrested more than once during the 12 months before entering the MHC were more likely to be arrested during the 12 months after entering the MHC. The authors also examined the relationship between the intensity of treatment services and rearrest and found no significant relationship between the two factors. They concluded that the MHC program was successful in reducing both the number of individuals who committed crimes and the total number of crimes committed by participants of the MHC, suggesting that there was a benefit to the mental health and criminal justice systems working closely together.

Christy, Poythress, Boothroyd, Petrila, and Mehra (2005) examined the efficacy and safety goals of the Broward County MHC. They compared arrest data and self-reported violence/aggressive behavior of MHC participants with a control sample from another county of individuals with mental illness who were not involved in MHC. They found that 47% of the MHC participants and 56% of the individuals from the comparison site had at least one rearrest one year after their initial arrest; however, this difference was not significant. The time spent in jail was significantly lower for MHC participants than for the comparison sample. The authors also examined whether reducing jail time for initial offenses for individuals with mental illness occurred at the cost of public safety. They found that self-reports by the participants did not suggest significantly higher rates of aggressive or violent behavior in MHC participants as compared to the comparison sample. The authors concluded that although individuals with mental illness were spending less time in jail relative to the comparison sample this had not occurred at the expense of public safety.

Boccaccini, Christy, Poythress, and Kershaw (2005) examined redirection of individuals in a jail diversion program (JDP) and an MHC. Redirection occurred when an individual was rearrested during or after participation in a JDP or MHC and was diverted again into the same program (JDP or MHC). The JDP was similar to MHC in that it diverted offenders from jail time to community mental health services; however, the programs differed in that the offenders in MHCs were supervised by the court, whereas offenders in the JDP were monitored in a manner similar to the procedures of inpatient or outpatient civil commitment. The authors found that one-fifth of participants in the JDP and MHC had redirected at least one time, and half of them those who had redirected had done so within 90 days of entering the program. The authors also reported that a disproportionate amount of services were being allocated to the participants who were being redirected multiple times. The results also indicated that those who were redirected tended to be younger and male. The authors suggested that it was unrealistic to believe that participants in diversion and MHC programs would not have any rearrests.

Cosden, Ellens, Schnell, and Yamini-Diouf (2005) conducted a study aimed at determining whether a California MHC that utilized an assertive community treatment (ACT) model of case management was effective in decreasing criminal activity and improving psychosocial functioning of participants. ACT is a method of case management that includes a team of mental health and criminal justice professionals who use an assertive method of encouragement for individuals with mental illness to improve their lifestyle. The team provided assistance and services to receive medication, housing, medical care, and employment. Contrary to findings by Herinckx

et al. (2005), when compared to a comparison group that included individuals receiving treatment as usual (TAU), there was no significant difference in the number of arrests, convictions, or jail time between the TAU group and the MHC group. However, when individuals whose criminal activity resulted in prison time after entering the MHC were excluded, there was a significant reduction in time spent in jail during the two years after entering the program in comparison to the two years before entering the program.

In terms of psychosocial functioning, Cosden et al. (2005) found that participants in the MHC had significant improvements in their global functioning and life satisfaction after entrance into the program relative to their functioning prior to entry into the MHC. In addition, there was a significant decrease in psychological distress and substance use after entering the program relative to levels prior to program entry.

Boothroyd, Mercado, Poythress, Christy, and Petrila (2005) examined clinically related outcomes. They specifically examined symptom reduction in offenders with mental illness who participated in MHC in comparison to offenders with mental illness those who did not participate in the MHC. Consistent to findings by Herinckx et al. (2005), Boothroyd et al. determined that MHC participants had increased access to mental health services in comparison to traditional court participants. On the other hand, they found no significant difference between MHC participants and traditional court participants in symptom reduction as measured by the Brief Psychiatric Rating Scale. The authors suggested that the failure to improve the clinical outcomes of participants in the MHC may not have been the result of the MHC being ineffective but rather a sign of the need for more effective community mental health services.

In a later study conducted by Moore and Hiday (2006), rearrest rates were compared for individuals who participated in MHC and individuals with mental illness who participated in a traditional court before the MHC was established. They found a significant difference in the two groups in terms of rearrest rates; specifically, the MHC participants had half the number of rearrests of the traditional court participants. The authors also reported that the rate of rearrests of MHC completers was one-fourth that of the rate of rearrests for traditional court participants. In addition, there was no significant difference between rearrest rates of traditional court participants and non-completers of the MHC.

McNiel and Binder (2007) also looked at the effectiveness of an MHC. They compared individuals with mental illness who participated in an MHC with individuals with mental illness who did not participate in MHC and were instead booked into jail after arrest. It should be noted that this study included individuals who had been charged with felonies as well as with misdemeanors. Similar to the results of Moore and Hiday (2006) and Herinckx et al. (2005), McNiel and Binder found that recidivism was reduced in the group who participated in MHC. All of the individuals who enrolled in MHC, despite whether they had successfully completed the program, had a longer time without any new charges than did those who did not participate in the program. After 18 months of participation, the offenders were 26% less likely than those not in the MHC to have a new charge. Also, those who graduated from MHC maintained reduced recidivism when they were no longer under supervision more frequently than did those who had not participated in MHC. The authors concluded that MHCs can lead to reduced recidivism in individuals with mental illness; they also

suggested that this reduction could occur for individuals who had committed felony offenses as well as misdemeanors and that it may be beneficial for MHCs to consider the inclusion of felony crimes more often in MHCs.

In a later study, Hiday and Ray (2010) examined the recidivism rates for a two-year period of 99 individuals who had exited a well-established MHC in North Carolina. The authors obtained arrest records for two years before the individual entered the MHC and two years after the individual exited the MHC. Approximately 61% of the individuals studied successfully completed the MHC program, whereas approximately 39% either opted out prior to completion or were ejected from the program. Although at least one re-arrest was common for individuals participating in the MHC, it was determined that more individuals who did not complete the program were arrested during the time they were involved with the MHC than were those who completed the program (58% and 20%, respectively).

With regard to re-arrest during the two year period after exiting the MHC, Hiday and Ray (2010) found that 48% had been arrested after exiting. However, this rate was significantly lower than the 97% arrest rate for the two years prior to the individuals entering the MHC. The authors also found that 72% of those who completed the program were not re-arrested in the two -year period after they exited, whereas 81% of those who were ejected were re-arrested. When analyzing factors that predicted re-arrest, the authors found prior arrests was a predictor and that those who completed the program were 88% less likely to be re-arrested relative to those who were ejected from the program . The authors concluded that, similar to results found in previous studies,

MHCs were effective in reducing recidivism, especially in those who complete a MHC program.

In a study conducted in Washoe County, Nevada, Frailing (2010) explored outcomes of individuals who participated and/or graduated in 2007. The authors specifically examined the number of jail days and psychiatric hospital days of three groups: individuals who were enrolled in 2007, individuals who had completed the MHC program in 2007, and individuals who had been referred but who did not enter the MHC in 2007 (i.e., a comparison group). They found that the year before referral to the MHC the MHC participants and the comparison group had similar number of jail days. It was also indicated that the MHC group spent significantly less time in jail than the control group a year after the referral. In addition, those who graduated spent less jail time during the year after completing the program than they had during the year after referral. The number of days spent in a psychiatric hospital was also significantly lower during the year after graduation than in the year before enrollment in the MHC.

Wales, Hiday, and Ray (2010) conducted a study to explore how MHC participants perceived procedural justice by judges in eight MHCs. They conducted interviews with 80 MHC participants and inquired about their perceptions of having voice and validation in their decision to enter the MHC. On these questions it was found that approximately two-thirds of the participants agreed or strongly agreed to the items that indicated they felt they had had voice and validation in this decision. They were also asked questions that were intended to measure the perceptions of having a voice and having experienced beneficence, respect, and fairness during their monthly hearing. Four-fifths of the questions were answered “definitely.” The authors

concluded that procedural justice and the participants' positive experience of this procedural justice by the judge is an important role of the MHC and could be important in the effectiveness of the MHC.

The views of stakeholders involved in a court that accepted individuals charged with more serious offenses were explored in a qualitative study conducted by McNiel and Binder (2010). They interviewed 43 professionals, including judges, attorneys, probation officers, case managers, psychiatrists, and administrators from agencies. They found that there was an overall positive perception of the MHC by stakeholders. A number of important aspects and issues were commonly identified by the stakeholders. One of these aspects was that the pre-adjudication model utilized by this court served to mitigate the potential for individuals to become involved more than was necessary by requiring a guilty plea in order to be accepted by the court. Another aspect that seemed to be agreed upon was that participation in the MHC was voluntary. However, some stakeholders mentioned concern about the level of voluntariness when the potential participant believed that the alternative to MHC was jail. Another common theme appeared in what the stakeholders believed indicated effectiveness of the MHC. Although most mentioned reduced recidivism, other outcomes included fewer days in jail, increased treatment, reduced symptoms, reduced substance use, reduced homelessness, and increased quality of life. In addition to the outcomes, stakeholders had a number of ideas of what the mechanisms for these outcomes may be, including adhering to treatment which reduces criminal behaviors, having supportive relationships, having ongoing supervision, obtaining linkage to housing, and having encouragement.

Stakeholders in the McNiel and Binder (2010) study appeared to have mixed opinions about the use of jail sanctions. Some participants believed that jail sanctions were counterproductive with the MHC population, whereas others believed that there needed to be more limits in place for individuals who did not adhere to the conditions of the court. The issue of MHC capacity also demonstrated mixed views. Some believed that the MHC could provide service to more individuals, whereas others felt that serving more participants would result in fewer resources and services for those involved in the MHC.

An issue that was raised in McNiel and Binder's (2010) study was whether the MHC increased the involvement in the criminal justice system in the initial processes when the individual had increased supervision or was waiting in jail for a treatment facility to accept him or her. Another concern that tended to be raised by stakeholders was that there were limitations in the available treatment resources, as well as in housing, benefits, and employment opportunities.

Sarteschi, Vaughn, and Kim (2011) recently conducted a meta-analysis of effectiveness of MHCs. The authors analyzed 18 studies that met criteria developed to ensure that the studies were comparable based on sample, outcome variables, and quality of the study. In terms of recidivism, the authors found an effect size of -0.54, indicating that the MHCs were moderately effective in reducing recidivism. In terms of affecting clinical outcomes of MHC participants, the authors reported that there may be an impact on GAF scores and a decrease in emergency room visits. They concluded that the greatest impact of MHCs was the reduction in recidivism by the individuals involved.

Due to the recent development of MHCs, there have not been a large number of studies that examine the effectiveness of MHCs. Studies also vary in their definitions of effectiveness. Overall, it appears that MHCs have been shown to be effective in reducing recidivism and providing mental health services to individuals with mental illness (Boothroyd et al., 2005; Christy et al., 2005; Cosden et al., 2005; Frailing, 2010; Herinckx et al., 2005; Hiday & Ray; McNiel & Binder, 2007; Moore & Hiday, 2006; Sarteschi et al., 2011). On the other hand, Boothroyd et al. (2005) found that MHCs may not be effective in improving clinical outcomes.

Purpose of the Current Study

Existing studies conducted to examine the effectiveness of MHCs seem to consistently indicate that MHCs can be beneficial to the legal system. Researchers have tended to focus on rates at which individuals have succeeded or not succeeded in MHCs (e.g., have not reoffended), with little information about possible reasons for the outcome. In this study, I examined variables that may affect the progress of individuals in a mental health court in Washington County, Oregon. The purpose of the current study was, first, to determine if individuals were making progress in the MHC, and, second, to determine if any common factors appeared to be related to their progress.

Method

Mental Health Court Design

The following information about the Washington County MHC was obtained through discussion with Joe Simich (personal communication, April 1, 2010). The Washington County MHC was started in April 2009 in attempt to assist individuals with mental health issues receive treatment and successfully complete probation. Individuals can be referred to the MHC by judges, probation officers, and case managers. The individuals who are referred tend to frequent the legal system and must meet criteria. Criteria for referral include having an Axis I diagnosis, having a history of substance abuse, being considered a nonviolent offender, and being on probation in Washington County

A team of court staff and mental health providers are involved in determining the how to approach each MHC participant's case. Individuals are determined to be in one of three phases based on completion of goals and adherence to conditions of probation. The phase that the participant is in also determines how often he or she must attend court to check in with the judge and how often he or she must check in with the probation officer. Individuals in Phase I must attend the MHC every 2 weeks (i.e., bi-weekly) and check in with the probation officer on weeks when they are not in court. Individuals in Phase II must attend one of the bi-monthly court hearings and check in with the probation officer two times a month. Individuals in Phases III must attend court once a month and check in with the probation office once a month. Individuals who successfully move through the

phases ultimately graduate from the MHC after fulfilling their goals in each phase (personal communication, April 1, 2010).

Participants

At the time of study initiation, 33 individuals were enrolled in the MHC and at the time data collection was complete 27 individuals were enrolled. All individuals in the MHC were eligible to participate in the study. There were a total 19 participants (9 males, 10 females). The mean age was 41.63 years ($SD = 13.69$), with a range from 20 to 64 years. Demographics of the participants are presented in Table 1.

Table 1

Demographics of Participants

	<i>n</i>	<i>%</i>
Ethnicity		
Caucasian	15	78.9
Latino	1	5.3
Korean	1	5.3
Pacific Islander	1	5.3
African American	1	5.3
Gender		
Female	10	52.6
Male	9	47.4
Level of education		
12 th grade or less	3	26
Some college/vocational	12	20
College degree	3	18

Table 1 continued

	<i>n</i>	<i>%</i>
Diagnosis in records		
Mood Disorder	9	47.4
Psychotic Disorder	3	15.8
Anxiety Disorder	1	5.3
MRDD/ADHD	2	10.5
Not Available	3	15.8
Charges*		
Theft (I, II, III, aggravated)	10	20
Forgery (II and possession of instrument)	2	10.5
Violation of a Restraining Order	2	10.5
Identity Theft	1	5.3
Tampering with Drug Record	1	5.3
Assault (II, IV, and of an officer)	4	21.0
Criminal Mischief/ Disorderly Conduct	2	10.5
Driving Under the Influence	2	10.5
Possession of a Controlled Substance	1	5.3
Harassment	1	5.3
Reckless Endangerment/ Reckless Driving	2	10.5
Stalking	1	5.3
Felony Possession of a Weapon	1	5.3
Phase		
I	14	73.7
II	1	5.3
III	4	21

* Some participants were charged with more than one offense, resulting in a total percentage that is greater than 100%

Assessment Measures

RAMP. The RAMP was developed by Von Arx and McWilliams (2009) to evaluate progress and outcome of participants in the Washington County MHC. There are currently no studies to determine the psychometric properties of this measure. The RAMP is divided into two components – Results Assessment (RA) and Monitoring Progress (MP). In the RA section, 16 domains (e.g., housing status, medication compliance, treatment participation, employment, and support systems) are rated by the court coordinator or the probation officer on a scale from 1 to 5. Generally, a score of 1 reflects instability and/or high risk, and a score of 5 reflects stability and/or low risk; the rankings are specified more precisely for each domain. These ratings are determined after an interview with the participant. The domains and specified rankings can be found in the interview form in Appendix A. In addition to these 16 domains, two separate domains are used to assess the number of days spent in jail and/or hospital in the prior 6 months.

The initial RA ratings were ideally assigned within the first 2 weeks of entry into the MHC and at the time of data collection there had not been a follow-up rating assigned; therefore, the follow-up was obtained during the interview process. Seven participants did not receive RA ratings because they had been enrolled in the court before the RAMP was introduced. For these individuals the probation officer estimated what their scores would have been at the time of their entrance into the MHC based on his knowledge of the individual and records kept on the individual.

The MP component of the RAMP contains the Goal Achievement Scale (GAS), which is used to assign a rating ranging from -2 to +2 to assess the level of achievement

of participants' goals. A rating of -2 signifies that the individual has not achieved his or her goal, a +2 signifies he or she has achieved the goal more than successfully, and a 0 signifies he or she has achieved the goal without going under or above expectations. Goals for the participant are divided into three categories and are determined within 6 weeks of admission into the MHC. The three categories include (a) court goals (which are the same for all participants), (b) safety goals (also the same for all participants), and (c) action goals (individualized goals specific to each participant's needs). The goals for each participant are discussed with the participant by the MHC probation officer and are then passed on to the mental health coordinator who clarifies each GAS rating by assigning what the client needs to accomplish or not accomplish for each rating of -2 to +2.

At the time of this study, a majority of the action goals for the participants included paying court fees and engaging in community service; however, a few participants had additional goals (e.g., avoiding department stores or not obtaining a bank account). Also, the GAS rating had not been utilized. As such, a statistical analysis of this section of the RAMP was not possible; however, the information was considered in other non-statistical analyses.

Perceived Procedural Justice. Participants' perceived procedural justice (PPJ) was assessed during the interview using a 5-item measure that was similar to a 5-item PPJ measure used by Poythress et al. (2002), discussed previously. The original measure used a 7-point Likert scale on which participants were asked to rate the level of agreement on statements about his or her perceived procedural justice. This scale was shown to have internal consistency that ranged from .56 to .85. For the current study,

participants were asked to rate their agreement with each item on a scale of 1 (*not at all*) to 5 (*definitely*). The items are included in the interview form in Appendix B.

Impact of Court Sessions. The impact of court hearings was also assessed during the interview using a 6-item measure that was similar to a 6-item impact of hearing measure used by Poythress et al. (2002), discussed previously. The original scale used a 7-point Likert scale in which participants were asked to rate their emotions after a court hearing. For example, they would be asked if they felt worse or better on a scale ranging from 1 (*worse*) to 7 (*better*). This scale was shown to have internal consistency of .78. For the current study, participants were asked to rate their agreement with each of the emotions separately rather than on the continuum used in the Poythress et al study. Each item was rated on a scale of 1 (*not at all*) to 5 (*definitely*). The items are included in the interview form in Appendix C.

Ratings of Mental Health Court Staff. Individuals were also asked to rate their perception of MHC staff with whom they had consistent contact (i.e., judge, probation officer, court coordinator, defense attorney, and others they may frequently have contact with) on a scale of 1 (*positive perception*) to 10 (*negative perception*). These ratings were averaged for the purpose of analysis.

Procedure

Individuals who were enrolled in the MHC were informed of the study by either hearing an announcement I made during the bi-monthly court hearing or being told about it by the probation officer during their regular appointments. Individuals who showed interest were presented with a more detailed description of the study and the requirements of participation. Individuals who agreed to participate were provided with an informed

consent in which details of the study as well as information about participant rights were discussed. If the individual agreed to the informed consent, an interview was conducted at that time.

Interviews took place at the Washington County probation and parole office. They were approximately 20-45 min in length and included questions about the participant's support system, housing situation, treatment, and so forth. The form used to gather this information is presented in Appendix D. In addition to these questions, the PPJ and ICS items were presented to the participant, and participants were also asked questions designed to permit assignment of a current RA score. Information was also obtained from participants' records, including mental health diagnosis, nature of current offense, initial RA scores, date of MHC entrance, phase the participant was in at the time of interview, and information about why they were at a particular phase.

Results

Descriptive Statistics

Descriptive statistics were calculated for the numerical variables including the number of days the participants had been involved in MHC, initial RAMP scores, RAMP scores at the time of the interview, the difference between initial RAMP scores and scores at the time of the interview, ICS scores, PPJ scores, and the average of each participant's ratings of the MHC staff. The results are displayed in Table 2. Due to the small sample size, the median is likely to be a better measure of central tendency than the mean, and thus both are provided.

Table 2

Descriptive Statistics for Numerical Variables (N = 19)

	<i>M</i>	<i>Mdn</i>	<i>SD</i>
Days in MHC	487.95	416.0	335.93
Initial RAMP score	46.11	48.0	7.13
RAMP score at the time of interview	26.00	25.0	6.88
Difference	20.12	20.0	8.20
ICS	34.58	34.0	3.96
PPJ	22.32	24.0	3.42
Average MHC staff ratings	8.21	8.6	1.82

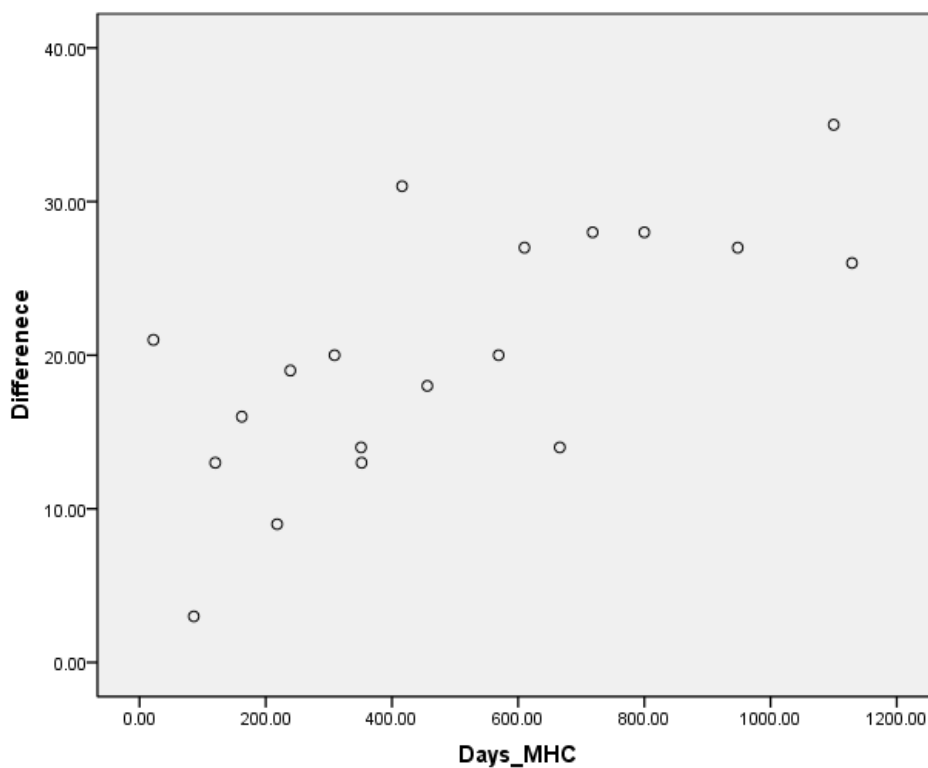
Correlational Analysis

A Pearson product-moment correlation coefficient was computed to determine the relationship between the numbers of days that the participants had been involved in the MHC and the RAMP difference score (calculated as the difference between the

participant's initial RAMP score and his or her score at the time of the interview; a larger difference score indicates more progress). A positive correlation between these two variables was found, $r = .70$, $p = \leq .001$. See Figure 1 for a scatter plot of the results. These results indicate that individuals who had been involved in the MHC for a greater number of days tended to have a greater difference between their initial RAMP scores and their RAMP scores at the time of the interview.

Figure 1

Scatter Plot of Days Involved in Mental Health Court and RAMP difference scores



Pearson product-moment correlations were also calculated to determine the relationships between the RAMP difference scores and ICS, RAMP difference scores and PPJ, RAMP difference scores and average ratings of MHC staff, ICS and PPJ, ICS and average ratings of MHC staff, and PPJ and average ratings of MHC staff. The results are

presented in Table 3. Significant correlations were found between the PPJ and average ratings of MHC staff, PPJ and ICS, and ICS and average ratings for MHC staff.

Table 3

Results for Pearson product-moment correlations

Measure	RDS	PPJ	ICS	AR
RAMP difference score (RDS)	–	.096	.302	-.053
PPJ	–	–	.675**	.627**
ICS	–	–	–	.470*
Average rating of MHC staff (AR)	–	–	–	–

**p < .01

* p < .001

Nonparametric Tests

Mann-Whitney U Tests were conducted to determine if there were significant differences in median scores on the RAMP for variables that could be divided into two groups based on whether a variable was present or not present for participants. In addition, Kruskal-Wallis Tests were conducted to determine if there were significant differences in median scores on the RAMP for variables that were divided into more than two groups. There were no significant differences, but the variables and group RAMP difference score medians are presented in Table 4.

Table 4

Median scores on the RAMP

	<i>N</i>	Mdn
Individual Treatment		
Yes	14	19.5
No	5	20.0
Group Treatment		
Yes	4	23.5
No	15	19.0
Employed		
Yes	4	26.5
No	15	18.0
Phase Set Back		
Yes	3	27.0
No	16	19.5
Highest Grade Completed in School		
12 th grade or less	3	26.0
Some college/vocational	12	20.0
College degree	3	18.0
Support		
Highly supportive	10	20.0
Not plentiful but available	7	21.0
Few sources	2	11.0
Housing		
Alone	6	20.0
With others	9	16.0
Group home/treatment facility	4	24.0

It should be noted that there was a change in judge in the midst of data collection that may have affected scores on the perception measures. To examine any effects of the change on the perception measures, a Mann-Whitney U was conducted to determine if there was a significant difference in the median scores on the perception measures between participants who were interviewed before the change in judge and after the change in judge. There were no significant results, but the median scores for before and after the change are presented in Table 5.

Table 5

Median scores on perception measures before and after change in judge

Measure	Before change in judge ($n = 8$)	After change in judge ($n = 10$)
PPJ	23.50	25.50
ICS	33.50	35.50
Average rating of MHC staff	7.25	9.25

Nonstatistical Observations and Trends

For the purpose of determining any notable trends in the data, I examined characteristics and scores on variables for participants who were in several categories: Phase III, were set back to Phase I, had a large RAMP difference score, had a small RAMP difference score, were not satisfied with the MHC, had been enrolled for more than 800 days, and had been enrolled for less than 200 days.

Phase III. Data for participants who were in Phase III at the time of the interview ($n = 4$) were examined. Trends that were observed were as follow: (a) all attended individual treatment, (b) all reported having a support system that was highly supportive or not plentiful but available, (c) all reported a high level of satisfaction with the MHC,

(d) none had ever been set back to a lower phase, (e) all had been involved in the MHC for a number of days that was at or above the median, (f) all had RAMP difference scores that were above both the mean and median, (g) 75% had a score on the PPJ that was at or above the mean and median, (h) all had a score on the ICS that was below the mean and median, and (i) 75% gave an average rating of MHC staff that was at or above the mean and median.

Phase set back. Data for participants who had been set back to a lower phase ($n = 3$) were examined. Trends were as follows: (a) ages were all below the mean and median (i.e., were 33 years old or younger), (b) two had RAMP difference scores that were above the mean and median, (c) two had a score on the PPJ that was above the mean and median, (d) all had a score on the ICS that was below the mean and median, (e) two had given an average rating of MHC staff that was at or below the mean and median, and (f) all had been set back for committing new crimes.

Largest RAMP difference scores. Data for the four participants who had the largest differences in the initial RAMP score and score at the time of the interview were examined. Trends were as follows: (a) all reported a high level of satisfaction with the MHC, (b) all had been involved in the MHC for a number of days that was at or above the mean and median, (c) all had a score of 25 on the PPJ (i.e., the maximum score), (d) all had a score on the ICS that was below the mean and median, and (e) 75% had given an average rating of MHC staff that was above the mean and median.

Smallest RAMP difference scores. Data for participants who had the smallest differences ($n = 5$) in the initial RAMP score and score at the time of the interview were examined. Trends were as follows: (a) all had some college or a college degree, (b) all

were in Phase I, (c) 60% reported high satisfaction with the MHC, (d) 60% of the scores on the PPJ were at or above the median, (e) all had a score on the ICS that was below the mean and median, and (f) 60% had given average ratings of MHC staff at or above the median.

Participants who were not satisfied. Data for participants who reported that they were not satisfied with the MHC ($n = 4$) were examined and the trends were as follows: (a) all were in Phase I, (b) 50% reported that they had an inadequate support system, (c) all reported having had a jail sanction imposed on them in MHC, (d) 75% reported having a negative court experience prior to MHC, (e) 75% had been involved in the MHC for a number of days that was below the mean and median, (f) 75% had a PPJ score that was at or below the median, (g) 75% had a ICS score that was at or above the median, and (h) 75% of the average ratings of MHC staff were below the mean and median.

Participants enrolled more than 800 days. Data for participants who had been enrolled in the MHC for 800 days or more ($n = 4$) were examined. The trends were as follows: (a) all were involved in individual therapy, (b) all reported high satisfaction, (c) none were set back to a lower phase, (d) 75% had a score of 25 (maximum score) on the PPJ, (e) all had scores on the ICS that were at or above the mean and median, and (f) half of the average ratings of MHC staff were at or above the mean and median.

Participants enrolled fewer than 200 days. Data for participants who had been enrolled in the MHC for fewer than 200 days ($n = 4$) were examined. The trends were as follows: (a) 75% reported satisfaction with the MHC, (b) 75% reported living with their family, (c) 75% reported having had a negative court experience before MHC, (d) 50% had a score on the PPJ that was less than the median, (e) 50% had a score on the ICS that

was less than the median, and (f) 50% had an average rating of MHC staff that was below the median.

Discussion

As noted above, the purpose of the current study was, first, to determine if individuals were making progress in the MHC, and, second, to determine if any common factors appeared to be related to their progress. Progress was defined as the difference between RAMP scores obtained when the participant entered the MHC and RAMP scores obtained at the time of interview. In addition, notable trends for participants were observed.

Summary of Results

Descriptive statistics. The descriptive statistics reported for the RAMP difference scores, PPJ, ICS, and average ratings of MHC staff appear to indicate that, overall, participants had positive perceptions of the court and staff and had made considerable improvement. This result is consistent with findings by Cosden et al. (2005) who found that participants in an MHC made significant improvements in their global functioning and experienced reduced psychological distress and substance use after entering the MHC. The factors measured by Cosden et al. were similar to items included on the RAMP. In addition, the high mean and median on the PPJ and ICS suggest that, overall, participants believed they were treated with respect and had opportunities to voice their views, and they experienced positive emotions after court. These are similar to findings by Poythress et al. (2002) in a study in which they used scales similar to those used in the current study. Poythress et al. also found that participants reported strong ratings of procedural justice and positive feelings after court status hearings. Further, Wales et al. (2010) found that a majority of participants believed they had a voice in court and had experienced beneficence, respect and fairness.

Correlations. The differences between initial RAMP scores and RAMP scores at the time of the interview indicated that all participants made progress in the MHC. Correlation coefficients were computed to determine if there was a relationship between the RAMP difference scores and the number of days that individuals were involved in the MHC. A strong positive correlation was found, indicating that individuals who had been involved in the MHC longer showed more improvement on the items included on the RAMP. It should be noted that having been involved in MHC for a longer time could also indicate that the individual was having difficulty meeting specific goals or conditions of probation necessary to graduate; however, it appears that they made improvements in areas of their life that were reflected on the RAMP (e.g., suicidal/homicidal thoughts, housing situations, engagement in treatment, etc.). This result may suggest that, although legal requirements may not have been met as yet, areas related to mental health and functioning did improve the longer the participant was in MHC.

In addition, RAMP difference scores were examined in relation to perceptions of the participants' experience in MHC and MHC staff by calculating correlation coefficients between RAMP difference scores and totals of the ICS, PPJ, and average ratings of MHC staff. Results indicated that there were no significant relationships between the RAMP difference scores and the other measures. A lack of significant results suggests that feeling respected and having opportunity to share one's own view and be heard (PPJ), having positive or negative feelings after court status hearings (ICS), and having perceptions of MHC staff were not associated with improvements on the RAMP measure. The lack of correlation with the PPJ is not consistent with the trends and observations that will be discussed later. The four participants who had the highest

RAMP difference scores also obtained the maximum PPJ scores, as such, this lack of correlation may be due to a small sample size. The lack of correlation with ICS and perceptions of MHC staff is contrary to what would be expected and is difficult to determine the reason for this.

Correlation coefficients were also computed to determine if there were any relationships among any of the measures of perception (i.e., PPJ, ICS, and average ratings of MHC staff). A significant positive correlation was found between PPJ and the average ratings of MHC staff, indicating that positive views of MHC staff were related to participants feeling respected and believing they had the opportunity to discuss their views in the court. There was also a significant correlation between PPJ and ICS, which indicates that there is a relationship between participants' feelings of being respected and how they feel about their experience after court sessions. Finally, there was a correlation between ICS and average ratings of MHC staff and indicating that there is a relationship between how participants feel after court and their perceptions of the MHC staff. Based on these correlations, it appears likely that how participants feel after court, their perceptions of MHC staff, and their feelings of being respected and given the opportunities to voice their views are all interrelated.

Nonparametric tests. Also examined were factors in the study that may be related to larger RAMP difference scores. Mann-Whitney U and Kruskal-Wallis Tests were conducted to compare median differences in RAMP scores between groups of participants. There were no significant results on these tests, probably due to the small sample size. However, there were some noticeable, if not significant, differences (i.e., a difference of 5 or more points) between groups. The median RAMP difference score for

individuals who were employed ($n = 4$) was larger than the median score for those who were not employed ($n = 15$). Level of education also yielded a noticeable difference. This factor was divided into three levels: 12th grade or below, some college or vocational school, and college degree. The group with a 12th-grade education or less had a median difference score that was noticeably larger than the group that had a college degree.

Interestingly, individuals who had been set back to Phase I after being in Phase II or III had a larger median RAMP difference score than did those who had not been set back. This finding could be explained by the relationship between RAMP difference scores and number of days in the MHC because the individuals who were set back tended to have been in the MHC for a number of days that was above the median.

Perceived source of support was also divided into three groups: highly supportive, not plentiful but available, and few sources. The median of the group who reported having few sources of support was noticeably lower than the other two groups. This finding suggests that individuals who believed that they had adequate or available sources of support might have shown greater improvements on the RAMP items.

Finally, different housing situations also seemed to have noticeable differences. Although there was a small difference between living alone and living with others (e.g., roommate, family, etc.), there was a difference greater than 5 points between living with others and living in a group home or treatment facility. Individuals living in a group home or treatment facility had larger RAMP difference scores than did those who were living with others. This finding may reflect the effects of living in a very structured and supervised environment where the individuals received ongoing mental health treatment and medication management.

A Mann-Whitney U Test was also conducted to determine if there was a difference in the median scores on the measures of perception (PPJ, ICS, and average rating of MHC staff) for participants before and after a change in judge. Although there were not significant differences for any of the measures. It is possible that the lack of significant results was due to a small sample size. If so this slight increase in the medians for each of the measures. This slight increase may be due simply to a preference of one judge over the other. However, a more likely reason may be related to anticipation of the change. Most of the participants were aware months prior that a new judge may be appointed to the MHC. This anticipation of change in the court may have resulted in an overall reduction in perceived respect and opportunity to voice their views, and ratings of staff. Once the change occurred and was not perceived as a negative change the anticipation subsided and perceptions increased as reflected in these measures.

Observations and trends. Individuals who had similar responses on a single factor were examined to determine if there were any trends in other factors. The single factors that were examined were individuals who (a) were in Phase III, (b) were set back to Phase I, (c) had the largest RAMP difference scores, (d) had the smallest RAMP difference scores, (e) reported not being satisfied with the MHC, (f) had been in the MHC for more than 800 days, and (g) had been in the MHC for fewer than 200 days. All the trends and observations were presented in the Results section. In this section I will discuss the notable trends.

Most of the trends for participants who were in Phase III were not surprising. It appears that they were involved in therapy, had adequate support, had a large improvement in RAMP scores, and so forth. One of the more interesting observations

was that all the individuals in Phase III had a total ICS score that was below the mean and median, indicating that these individuals experienced less positive feelings after court status hearings. This finding may be related to the amount of time they have dedicated to completing MHC; they may enjoy court less than when they had first entered.

Only three participants had been set back to Phase I from Phase II or III so it was difficult to identify trends for this group. Two observations could be made for the participants in this category. First, they were all 33 years old or younger. This is interesting considering that the mean and median age of participants was approximately 41; thus, these individuals were notably younger than the average participant. Second, they all had ICS scores that were below the mean and median. This trend seems to make sense; if the participants were not doing well in the court they may have received more critical feedback, resulting in more negative feelings after a court status hearing. It should also be noted that this finding is similar to those who had been set back to Phase I. This may be due to similar feelings that they have dedicated so much time to the court working towards phase II or III (only to be set back) and may enjoy court less than when they entered the MHC.

There were a few notable trends for participants who reported being unsatisfied with the MHC. First, a majority of them had negative court experience prior to MHC and had a jail sanction imposed on them in the MHC. It is possible that a previous negative experience in addition to having a negative experience (i.e., a jail sanction) in the MHC resulted in reduced satisfaction with MHC. It was also surprising that a majority of these participants had an ICS score that was at or above the median, indicating that they typically experience positive feelings after court status hearings.

When examining the participants who had the largest and smallest RAMP difference scores, a couple of trends stood out. The participants with large RAMP difference scores all reported satisfaction with MHC and had a maximum score on the PPJ, whereas the group that had small RAMP difference scores had fewer participants who reported satisfaction and fewer people who had high scores on the PPJ. This result may suggest that those who felt they were being respected and heard tended to improve more on the RAMP items. It should also be noted that all the participants in these two groups had ICS scores that were below the median, which could indicate that the participants' feelings after court status hearings were not related to how much a person improved on the RAMP.

Participants who had been involved in the MHC for more than 800 days and those who were involved for fewer than 200 days were also examined. It appeared that a majority of participants who had been involved with the MHC for more than 800 days reported having had positive experiences, as reflected in satisfaction ratings, high PPJ and ICS scores, and high average ratings of MHC staff, whereas at least half of the participants who had been involved in MHC for fewer than 200 days had low scores on the PPJ and ICS and had low average ratings of MHC staff. It should be noted that most of the participants in this group also reported satisfaction with the MHC. These observations may suggest that, although many individuals who had been in the MHC for a long period of time may not have been meeting their goals in order to graduate, they continued to have a positive experience in MHC. These observations may also indicate that participants developed negative perceptions when they first entered the MHC, but over time these perceptions become more positive.

Strengths and Limitations of the Current Research

The most prominent strength of this study is that it was the first known study to systematically explore factors that may be related to the level of progress made in mental health court. It also allowed identification of possible factors that may be related to perception of the MHC and staff. Further, it provided information that may be useful for more focused research, such as determining underlying reasons for the trends found in this study.

The biggest limitation of the current study was the small sample size. Due to the small number of individuals involved in the Washington County MHC (approximately 27), the number who could volunteer to participate in this study was also small. Nonparametric tests were used to analyze the data because of this issue; however, there were very few significant results, which may have at least in part reflected the small sample size. It should also be noted that the sample was not randomly selected; that is, participants volunteered to participate and may not be representative of the population.

Another limitation was that the method that was used to determine trends was simply to look at frequencies and descriptive statistics and make observations about apparent trends. Again, due to the small sample size, many of the groups observed for trends were rather small, and the trends that were found cannot be considered significant findings but simply observations based on the data.

Another limitation in the study was that major changes occurred in the composition of the MHC staff. This included a change in the probation officer and defense attorney right before data collection began and, perhaps most importantly, a change in the judge in the midst of data collection. These changes may have affected

scores on many of the measures that were included in the study (e.g., ratings of MHC staff, ICS scores, etc.). The change in judge was addressed previously; however, the changes in the probation officer and attorney could not be examined because data was not available before the changes.

Finally, because there is such variability in the characteristics and operations of MHCs across the country, and because the RAMP measure has not been used in other MHCs to date, it is difficult to generalize the findings to other courts. Additionally, diverse populations were not well-represented in the sample, resulting in more difficulty in generalizing the results to other populations.

Implications of the Current Study

The most concrete implications of this study are based on the significant correlations. The first correlation indicates a positive relationship between the number of days that a participant was involved in the MHC and RAMP difference scores. A high number of days might indicate that participants were not meeting goals, such as conditions of probation, that would allow them to graduate. Yet, areas that were reflected in the RAMP, some of which were conditions of probation but others that were mental health related, were improving. This suggests that the structure and resources that the court provides can benefit participants in ways that may not be recognized if they fail to progress through the phases. As such, progress should be viewed in multiple ways, such as improvement in mental health and problem behaviors.

The remaining significant correlation indicated that there was a positive relationship between most of the perception measures (i.e., PPJ, ICS, and average rating of MHC staff). These relationships suggest that participants' perceptions of staff, their

feelings of being respected and heard, and their feelings after court sessions are all interrelated. Thus, MHC staff should keep these relationships and perceptions in mind when interacting with participants and continue to treat them with respect and allow them to voice their views.

Although there were no other significant results, likely due to the small sample size, non-significant results could have implications as well. The exploration of differences between median RAMP difference scores for different levels of individual factors (e.g., education, support system) indicated that there were some differences that could be informative. For example, individuals who were employed (i.e., part-time), those who had highly supportive or at least available support systems, and those who lived in a group home or treatment facility tended to have a large difference in RAMP scores. Thus, it may be beneficial for staff to focus on providing resources for participants in these areas.

The trends and observations also provided useful information. One trend that should be considered is that individuals who reported not being satisfied with the MHC had also had jail sanctions. Further, individuals who had the largest RAMP differences reported satisfaction with the MHC. As such, imposing jail sanctions may reduce satisfaction and indirectly affect improvement in areas reflected in the RAMP.

Another trend that may have implications is that all the participants who were in Phase III were involved in individual therapy. Although this was a small group to examine, individual therapy may increase an individual's ability to meet goals and graduate from the MHC. As such, it may be beneficial to encourage or mandate MHC participants to receive therapy.

Also, trends seemed to indicate that overall satisfaction may be related to perceived procedural justice and perceptions of MHC staff. As mentioned previously, individuals who had the largest RAMP difference scores also reported satisfaction with the MHC. As such, continuing to provide have positive interactions and treating the participants fairly and with respect may also be an important consideration that could result in improvement on the RAMP.

Directions for Future Research

A replication of this study with a larger sample size would be helpful in confirming relationships and trends found in this study. In addition, obtaining a random sample of MHC participants in a number of MHCs in different locations would improve the generalizability. In addition, to date there have been no validity or reliability studies conducted on the RAMP. It would be beneficial to conduct such research in order to establish the psychometric properties of the RAMP, to refine its items, and to assess whether it can be utilized by other MHCs. Finally, now that the Washington County MHC has been operating for a few years, an increasing number of participants are graduating. It would be interesting to determine if any RAMP factors are predictive of recidivism.

Conclusions

The purpose of this study was to explore possible explanations for MHC participants' progress as measured by the RAMP. A significant positive relationship was found between differences in RAMP scores and the days the participant had been involved in MHC. There was also a positive relationship between participants'

perceptions of MHC staff and their perception of procedural justice. A number of nonsignificant findings may also be informative, such as factors that may be related to improvement based on RAMP scores (e.g., employment, strong support system, and living in a group home or treatment facility). A number of trends were observed that can provide information for MHC staff to consider. More research is needed to confirm and expand on the findings in the study as well as studies to determine the validity and reliability of the RAMP.

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Appendix A

RESULTS ASSESSMENT QUESTIONNAIRE

To be completed by court staff prior to mental health court admission and upon graduation or termination from mental health court.

Directions: Rate the participant's status in each dimension. If no time period is indicated, consider past month.

A. Suicidal ideation and behaviors

Consider *intentionally* lethal thinking or behaviors, such as suicidal ideation, threats of suicide, or suicidal gestures.

1. No indication of suicidal thoughts or impulses.
2. Some minor suicidal ideation such as occasional passing thoughts.
3. Significant suicidal ideation without intention or conscious plan.
4. Current suicidal ideation with a plan and available means to carry out plan.
5. Current suicidal behavior and intention.

B. Deliberate self harm without lethal intent

Consider deliberate self-harm or self-injury (deliberate infliction of tissue damage) *without suicidal intent*. Examples could include intentional cutting or burning.

1. No self-harm behaviors for the past six months.
2. No self-harm behaviors for the past month.
3. Some self-harm behaviors with low potential for lethality, such as shallow cutting on extremities.
4. Some self-harm behaviors with moderate potential for lethality.
5. Some self-harm behaviors with high potential for (unintentional) lethality.

C. Unintentional self harm

Consider behaviors involving high potential for *unintentional* harm. Examples could include operating motor vehicles under the influence of substances or riding with others who do so, visiting or sleeping in unsafe places, associating with people who have a known history of interpersonal violence, wandering into traffic, etc.

1. No unsafe behaviors or exposure to unsafe situations or environments.
2. Unsafe behaviors or exposure to unsafe environments 1-3 times over the past month with little potential for lethality.
3. Unsafe behaviors or exposure to unsafe environments on a weekly basis with little potential for lethality.
4. Unsafe behaviors or exposure to unsafe environments one or more times over the past month with moderate potential for lethality.
5. Unsafe behaviors or exposure to unsafe environments one or more times over the past month with high potential for lethality.

D. Violent or Aggressive Behavior

Consider behaviors such as family and interpersonal violence, violence in the community, and aggressive gestures or behaviors directed at others.

1. No incidences of violent or aggressive behavior in past six months.
2. No incidences of violent or aggressive behavior in past month.
3. One or more incidents of violent or aggressive behavior in the past month.
4. One or more incidents of violent or aggressive behavior in the past week.
5. Violent or aggressive behavior occurring daily.

E. Substance use

Consider use of alcohol and illicit substances.

1. No substance use within past year.
2. No substance use within past six months.
3. No substance use within past month.
4. Substances used one or more times in the past month.
5. Substances used one or more times in the past week.

F. Crimes or Probation Violations

Consider any recent criminal charges or probation violations.

1. No new crimes or probation violations in past six months.

2. No new crimes or probation violations in past month.
3. One or more crimes committed in past month, resulting in probation violation.
4. One or more crimes committed in past month, resulting in new misdemeanor charges.
5. One or more crimes committed in past month, resulting in new felony charges.

G. Restitution and Court Fees

Consider any restitution or court ordered financial obligations (COFOs). For community service, or court fees converted into community service, see next dimension.

1. Restitution/COFO's paid in full OR not applicable (client does not owe court fees).
2. Payment of at least half of money owed.
3. Some minimal payment made (at least $\frac{1}{4}$ of that assigned).
4. Little or no money paid, but movement towards goal (i.e. set up payment plan).
5. None of restitution/COFOs paid.

H. Community Service

Consider current total community service hours owed to the court.

1. All community service hours completed OR not applicable (no hours assigned).
2. Completion of at least half of community service hours.
3. Some minimal community service hours completed (at least $\frac{1}{4}$ of those assigned).
4. Few or no community service hours completed, but movement towards goal (i.e. application filled out for site, appointment set up for interview).
5. None of community service hours completed.

I. Treatment system involvement and attendance

Consider client participation in any treatment activities including individual treatment, groups, or 12-step program involvement. Consider both mental health and substance abuse treatment involvement.

1. Prior completion of treatment regimen OR regular attendance at current placement OR no treatment recommended by court/providers.
2. Current involvement with treatment system with few isolated absences.
3. Some contacts or appointments made with treatment provider, but few attended.
4. Client not currently involved with treatment, but some movement towards this (i.e. appointments set up, completion of intake).

5. Client not involved with any type of treatment.

J. Treatment engagement

For clients currently connected with one or more treatment activities, consider level of engagement based on provider report, attendance, compliance, etc.

1. High level of engagement in treatment, with consistent high levels of participation and compliance with treatment providers OR not applicable (client not involved in any type of treatment).
2. High level of engagement in treatment, with occasional non-compliance (i.e. not participating during one isolated group).
3. Client moderately engaged in treatment, or inconsistently engaged (i.e. some participation in groups, moderately willing to engage in individual treatment, inconsistent completion of homework assignments).
4. Client minimally engaged in treatment (i.e. rare participation in group, non-compliant in individual sessions, not taking responsibility for behaviors, does not see need for treatment that court staff does).
5. Client completely unengaged in treatment (i.e. refuses to attend, never participates in group).

K. Medication compliance

Consider compliance with medication instructions including accuracy (i.e. one pill taken at noon) and consistency (i.e. one pill taken each day).

1. 95% medication compliance for past six months OR not applicable (client not currently prescribed any medications).
2. 95% medication compliance for past month.
3. Medication is taken as prescribed most of the time, with some small errors (i.e. miss one dose).
4. Medication is taken inconsistently.
5. Medication is taken rarely or not at all.

L. Housing

Consider client's current housing status, including safety, living environment, stability, ability to make payments, etc.

1. Maintenance of stable housing for at least six months.
2. Maintenance of stable housing for at least one month.
3. Somewhat unstable housing (i.e. occasional doubt about ability to pay rent, some negative influences in the home).
4. Moderately unstable housing (i.e. living as guest in someone else's home, doubt each month about ability to pay rent, or substance use in home).
5. Currently homeless or highly unstable or unsafe housing.

M. Support System

Consider all support systems available to client, such as family, friends, mentors, sponsors, or people identified from community or faith based organizations. Of identified sources, consider both emotional support and instrumental support (i.e. housing, financial, transportation, etc.).

1. Highly supportive environment with multiple sources of support and assistance.
2. Sources of support are not plentiful but are willing to and capable of providing assistance.
3. A few sources of support are available in environment or could provide support if needed.
4. Minimal sources of support in environment, or persons identified as supportive are negative influences or coercive.
5. No sources of support or assistance are present in environment.

N. Employment or Education

Consider legitimate employment such that client can support self or make significant contribution to supporting themselves, OR participation in formal educational activities.

1. Currently demonstrating success in stable employment or educational activity.
2. Currently employed or involved in education with some minor instability, such as repeatedly missing days of work or school.
3. Currently employed or involved in education but in a markedly unstable situation, such as disciplinary action at work or failing grades.
4. Unemployed and not involved in education but some recent movement towards it, such as filling out multiple applications or completing entrance exams.
5. Unemployed and not involved in educational activities with no recent activity towards such.

O. Self care

Consider self-care behaviors such as taking showers, doing laundry, maintaining a clean living environment, etc.

1. Consistent and sufficient engagement in self-care behaviors.

2. Regular engagement in self-care and personal hygiene activities, with one or more isolated incidences of neglect.
3. Occasional engagement in self care and personal hygiene activities (i.e. once per week).
4. Rare completion of self-care and hygiene activities (i.e. once per month).
5. Consistent neglect of basic self-care and personal hygiene activities.

P. Overall Functional Status

Consider client's current overall level of functioning.

1. No current impairment in functioning.
2. Some minimal impairment in functioning, such as minor disruptions in usual activities, ability for self-care, or minor difficulties in attending to responsibilities.
3. Moderate impairment in overall functioning, such as serious deterioration in ability to address responsibilities, or consistent impairment in interpersonal relationships and/or ability for self-care.
4. Significant impairment in functioning, such as isolation and withdrawal from social interactions, pervasive inability to attend to responsibilities, or serious deterioration in interpersonal interactions.
5. Severe impairment in functioning, such as complete social withdrawal, erratic and unsafe behaviors, and complete inability to attend to responsibilities or maintain relationships.

Q. Days spent in jail in past six months _____

R. Days spent in hospital in past six months (for psychiatric reasons) _____

Appendix B

PERCEIVED PROCEDURAL JUSTICE

Scale of 1 (not at all) to 5 (definitely)

I have the opportunity to tell the judge important information about my situation.

The judge seems interested and invested in my success.

I feel respected.

I feel that I am treated fairly.

I'm satisfied with decisions made in court.

Appendix C

IMPACT OF COURT SESSIONS:

Scale of 1 (not at all) to 5 (definitely)

After a court session I usually feel

Better :

Worse:

Upset:

Calm:

Respected:

Disrespected:

More confused:

Less confused:

Hopeful:

Hopeless:

Appendix D

Data Form

DEMOGRAPHICS

Age:

Gender:

Ethnicity:

SES:

Marital Status:

Highest Grade of Education:

CLINICAL INFORMATION

Diagnosis:

Initial RAMP score:

Current RAMP score:

Relevant clinical information from file:

INTERVIEW INFORMATION:

Frequency of court attendance (expected vs. actual):

Frequency of individual therapy:

Frequency of group therapy:

Support System:

Type of housing:

Relationship with court staff:

Judge:

Court Coordinator:

Probation officer:

Mental health specialist:

Other:

Employment status:

School Status:

Past court experience:

Jail sanctions:

Overall satisfaction with the MHC:

PERCEIVED PROCEDURAL JUSTICE

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The judge seems interested and invested in my success.

I feel respected.

I feel that I am treated fairly.

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